FORM A: FACE PAGE

This form requests basic information about the Applicant and project, including the signature of the authorized representative. The face page must be completed in its entirety.

APPLICANT INFORMATION

1) LEGAL BUSINESS NAME: WOMEN'S HEALTH CARE CENTER, INC.

2) MAILING Address Information (include mailing address, street, city, county, state and zip code):
2914 S BUCKNER STE B DALLAS TEXAS 75227

3) PAYEE Name and Mailing Address (if different from above):

4) DUNS Number (9-digit): 829195259

5) Health and Human Service Region:

6) Federal Tax ID No. (9 digit), State of Texas Comptroller Vendor ID No. (14 digit) or Social Security Number (9 digit): 943432832

**The Applicant acknowledges, understands and agrees that the Applicant's choice to use a social security number as the vendor identification number for the contract, may result in the social security number being made public via state open records requests.*

7) TYPE OF ENTITY (check all that apply):

- ☐ City
- ☐ County
- ☐ Other Political Subdivision
- ☐ State Agency
- ☐ Indian Tribe
- ☒ Nonprofit Organization*
- ☐ For Profit Organization*
- ☐ HUB Certified
- ☐ Community-Based Organization
- ☐ Minority Organization
- ☐ Faith Based (Nonprofit Org)
- ☐ Individual
- ☐ Federally Qualified Health Centers
- ☐ State Controlled Institution of Higher Learning
- ☐ Hospital
- ☐ Private
- ☐ Other (specify):

**If incorporated, provide 10-digit charter number assigned by Secretary of State:* 0800987809

8) BUDGET PERIOD: Start Date: July 1, 2016 End Date: August 31, 2017

9) COUNTIES SERVED BY FAMILY PLANNING PROJECT: (complete Form C:Texas Counties and Regions) DALLAS

10) PRIMARY PLACE OF SERVICES PROVIDED 2914 S BUCKNER STE B DALLAS TEXAS 75227

11) TOTAL FUNDING REQUESTED: 300,000 Revised

Fee for Service: $300,000 | Categorical: 0

12) PROJECTED EXPENDITURES

Does Applicant's projected federal expenditures exceed $500,000, or its projected state expenditures exceed $500,000, for Applicant's current fiscal year (excluding amount requested in line 9 above)? **

Yes No X

***Projected expenditures should include anticipated expenditures under all federal grants including "pass through" federal funds from all state agencies, or all anticipated expenditures under state grants, as applicable.*

13) FAM[redacted]NG (FP) PRIMARY CONTACT PERSON
Name: [redacted]TENISON RN, EXECUTIVE DIRECTOR
Phone: 214-275-5256
Fax: 214-275-5284
Email:SHERRYTENISON@YAHOO.COM

14) FINANCIAL OFFICER
Name:
Donnie
Graham
Phone 214
Fax:214-
275-
5284
Email:Do
nnie
Graham
@

The facts affirmed by me in this proposal are truthful and I warrant the Applicant is in compliance with the assurances and certifications contained in **APPENDIX I: HHSC Assurances and Certifications.** I understand the truthfulness of the facts affirmed herein and the continuing compliance with these requirements are conditions precedent to the award of a contract. This document has been duly authorized by the governing body of the Applicant and I (the person signing below) am authorized to represent the Applicant.

15) AUTHORIZED REPRESENTATIVE

Name: Sherry Tenison RN Executive Director
Title: Executive Director

16) SIGNATURE OF AUTHORIZED REPRESENTATIVE [redacted] Revised

17) DATE 8/1/2016

Phone: 214-275-5256
Fax: 214-275-5284
Email: sherrytenison@yahoo.com

8-1-2016

Revised [redacted]